BENEFITS REPORT

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HEFFERNAN INSURANCE BROKERS

Because You're Different

OPEN ENROLLMENT PREP

SURVEY YOUR EMPLOYEES TO FINE-TUNE YOUR BENEFITS

AS THE year-end open enrollment period approaches, now is the time to fine-tune your benefits, and that starts with surveying your employees about their views of your current offerings.

There should be more to this effort than checking boxes. It's important that you elicit an honest assessment from your employees, and once you have their responses you need to process and analyze them with the goal of exploring changes that will benefit your staff.

Surveys are not exercises in futility. A recent study by Aflac found that while four out of five employers think their workers are satisfied with their benefits, only three in five employees say the same. That disconnect can result in employers offering benefits year after year that their staff may not value.

Offering the wrong benefits can be costly, considering that benefits account for between 30% and 40% of total compensation, according to the Bureau of Labor Statistics. That's a lot to spend on something you don't know is generating a solid return on investment.

Employee survey components

Areas you may want to cover in your survey include:

- General satisfaction with benefits and whether there are any they want but you don't offer.
- Health care coverage affordability, coverage depth and satisfaction with network breadth and access.
- Overall impressions, understanding and usefulness of current benefits.
- Participation in wellness programs, satisfaction with mental health support and learning opportunities.

Probe deeper into health benefits

You may want to dig deeper into views on your most important benefit, group health insurance, by asking questions like:

- How well does the current plan cover your needs?
- Are the current plan's deductibles and copayments fair?
- How easy is it to find in-network providers for the health care you need?
- Are there any specific types of specialists or facilities you wish were more accessible in our network?
- Does the current plan offer good value for the cost?
- How easy is it to understand your benefits and use them?
- How satisfied are you with the customer support you've received related to the health plan?
- How can we better communicate plan information?

See 'Surveys' on page 2

CONTACT US

If you have questions about your coverage or our products, please reach out to me:

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ACA COMPLIANCE

IRS HEALTH PLAN AFFORDABILITY THRESHOLDS INCREASE

THE IRS has significantly increased the group health plan affordability threshold, which is used to determine if an employer's lowest-premium health plan complies with Affordable Care Act rules, for plan years starting in 2026.

The threshold for next year has been set at 9.96% of an employee's household income, up from 9.02% this year.

The higher threshold will give employers more wiggle room when setting their workers' health insurance premium cost-sharing level to avoid running afoul of the ACA. In addition, penalties for failing to provide coverage that meets the affordability threshold will rise 15% in 2026.

Under the ACA, "applicable large employers" — those with 50 or more full-time or full-time equivalent employees — are required to offer at least one health plan to their workers that is considered affordable based on a percentage of the lowest-paid employee's household income.

If an employer's plan fails this test, it will be deemed non-compliant with the law, resulting in penalties for the employer.

The new threshold will apply to all health plans whenever they incept in 2026.

The affordability test applies only to the portion of premiums for self-only coverage, not family coverage. If an employer offers multiple health plans, the affordability test applies only to the lowest-cost option.

Calculating plan affordability

Employers can rely on one or more safe harbors when determining if coverage is affordable:

- The employee's most recent W-2 wages.
- The employee's rate of pay, which is the hourly wage rate multiplied by 130 hours per month.
- The federal poverty level.

Penalties

Failure to provide affordable coverage can result in a penalty of $5,010 per affected employee in 2026, up 15% from $4,350 in 2025.

Another penalty, known as the Employer Shared Responsibility Payment, will also increase. This penalty applies to employers that fail to offer minimum essential coverage to at least 95% of full-time employees and their dependents, and when at least one full-time employee purchases exchange coverage and receives a premium tax credit.

This penalty, which applies to the total number of full-time employees (minus the first 30), will rise to $3,340 per employee in 2026, also up 15%.

The above penalties are both indexed to inflation.

The takeaway

As 2026 approaches, it is important to review health plan costs and premium-sharing to ensure your lowest-cost option complies with the ACA affordability requirement.

We can help assess affordability and confirm your plans meet the standard, so your firm stays compliant.

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Surveys Shouldn't Take More Than 10 Minutes to Finish

Digging deep

The next step is picking through the answers to identify trends and areas of opportunity. As your health insurance broker, we can help you digest the information and develop a plan for you. We can also segment the findings by age, family status (kids or no kids) or job function to better personalize your offerings to match your employees' needs.

Once we do that, you can prioritize which potential actions make the most sense, are feasible and would make the largest impact. We can then make a plan that includes:

- **Short-term changes:** Low-cost, high-impact adjustments
- **Mid-term changes:** Plan design or contribution changes.
- **Long-term initiatives:** Introducing a new benefit category

Final thoughts

Even small improvements show employees that their voice matters. Just remember that people have short attention spans, so surveys shouldn't take longer than five or 10 minutes to complete.

Also, arrange for the surveys to be submitted anonymously so your staff will feel free to speak their minds.

Whatever changes you decide to make must also be communicated to the employees, so they understand what's coming and why the changes are being made. This shows that you took the survey seriously and responded with action.

Transparency builds credibility.

COST TRENDS

EMPLOYERS EXPECT HIGHER GROUP HEALTH COST INFLATION

EMPLOYERS ARE preparing for what could be the steepest annual increase in health care costs in more than a decade, and many are considering plan design changes, including cost-shifting, to buffer the impact, according to a new report.

The "2026 Employer Health Care Strategy Survey," conducted by the Business Group on Health, found that business executives project a median 9% rise in costs for 2026, but expect a 7.6% increase after making plan design changes to address major cost drivers. Here are the biggest concerns and how surveyed employers plan to address them.

1. Obesity treatments add pharmacy pressure

Pharmacy spending has grown to nearly a quarter of employer health care costs, driven largely by demand for GLP-1 drugs such as Wegovy, Mounjaro and Zepbound.

Employers report that 79% have already seen increased use of these medications, which are effective for both diabetes and weight loss. These treatments cost more than $1,000 per month.

Employers' GLP-1 strategies

- Requiring "step therapy," which involves trying proven, less expensive methods or medications before GLP-1s,
- Limiting prescriptions to employees with diabetes and a qualifying body mass index,
- Requiring prior authorization,
- Mandating participation in weight management programs,
- Approving prescriptions only from certain providers, and
- Reducing GLP-1 coverage altogether.

2. Cancer drives long-term costs

For the fourth straight year, cancer has topped the list of conditions driving employer health care expenses.

Rising diagnoses, delayed preventive care during the pandemic and an aging workforce are combining to push treatment costs higher.

In response, more employers are expanding cancer prevention and screening benefits, removing age limits for preventive screenings and covering access to cancer centers of excellence.

3. Mental health demand continues to grow

Nearly three-quarters of employers report higher use of mental health and substance use disorder services, with another 17% expecting further increases soon.

While nearly all employers now offer mental health support, the challenge is balancing costs with access to appropriate care.

Larger employers with more resources are providing access to centers dedicated to acute mental health conditions.

Cost-shifting and vendor changes

According to a recent Mercer survey, half of large employers said they will likely:

- Increase employee premium cost sharing,
- Raise deductibles, and/or
- Hike out-of-pocket maximums in 2026.

In the Business Group on Health study, most employers said they would consider shifting costs to workers if needed.

At the same time, companies are rethinking vendor relationships. Four in 10 employers reported changing or reviewing pharmacy benefit managers, while others are reassessing wellness and medical benefit partners.

Employers are looking for PBM models that are more transparent. Meanwhile, alternative health plans are gaining traction as employers look for greater value and predictability.

Recommendations

The Business Group on Health report noted that employers can do more than pass along costs to workers, by:

- Assessing the effectiveness of benefit programs and vendors, and eliminating those that deliver limited value.
- Helping employees, through training and an open-door policy for questions, use plan resources and navigation tools to find providers that deliver high-value care.
- Encouraging staff to stay on top of check-ups, doctor visits, medications, screenings, tests and immunizations.
- Requiring vendors to adopt transparent financial models, particularly for pharmacy benefits.

SURGING MENTAL HEALTH DEMAND: *Employers are trying to manage costs while increasing access to care.*

COVERAGE REGULATIONS

FEDS WON'T ENFORCE SHORT-TERM HEALTH INSURANCE LIMITS

The Departments of Labor, Treasury and Health and Human Services announced that they will no longer enforce a 2024 rule limiting short-term health insurance to three months.

The decision leaves the door open for insurers to once again issue these policies for up to three years, as they were permitted under rules implemented during President Trump's first term. The agencies emphasized that the rule itself remains in place but said they "do not intend to prioritize enforcement actions" against plans that exceed the Biden-era restrictions.

Officials also signaled that they are considering further changes to how these policies are regulated, though no timeline was outlined.

A political football kicked again

Short-term health plans have been a political crunch point across three administrations:

- **2016:** The Obama administration finalized a rule limiting plans to three months, calling them temporary stopgaps.
- **2018:** Trump extended the maximum duration to one year and allowed for renewals up to three years.
- **2024:** The Biden administration capped the plans at three months with no more than four months total coverage.

How the plans work

Short-term policies are typically less expensive than Affordable Care Act-compliant coverage because they are not subject to ACA rules. These plans were originally envisioned as a bridge between jobs or coverage transitions, not as long-term solutions.

Also, because short-term coverage is distinct from comprehensive health insurance, employers evaluating whether to steer workers toward these plans should understand the trade-offs:

- Preexisting conditions can be excluded.
- Coverage can be denied based on health history.
- Annual and lifetime benefit caps may apply.
- Preventive care, maternity care and mental health services are often not included.
- No protection under ACA consumer safeguards such as the No Surprises Act or parity requirements for mental health.

For smaller employers that are not subject to the ACA's mandate to offer affordable health coverage, short-term policies could be an option for workers seeking lower-cost alternatives.

State restrictions

While federal regulators are stepping back, states still control whether these plans can be sold within their borders.

Fourteen states plus the District of Columbia bar them altogether, including California, New York and New Jersey. Other states allow them but impose strict duration limits or conditions that make them impractical for insurers to offer.

Potential changes ahead

The agencies noted they are considering additional adjustments to the rules governing short-term plans. Possible areas of change could include:

- Redefining the maximum duration,
- Revisiting required consumer disclosures,
- Imposing new standards for renewals, and
- Allowing for stacking of policies.

Any proposed rulemaking would undergo a public comment process before becoming final.

Takeaway for employers

The federal decision creates uncertainty in the market, with enforcement discretion now favoring longer short-term policies but no clear timeline on new rules.

Employers with fewer than 50 employees may see these plans as a possible option for workers, but larger employers remain bound by ACA requirements to provide affordable, minimum-value coverage.

As the agencies move toward potential new regulations, employers should monitor developments closely and weigh the risks and limitations of short-term health plans before considering them as part of a benefits strategy.